Record Keeping and Documentation

Case records maintained by the Early Interventionist are considered by SCDDSN to be the child's primary case records with DDSN. Primary case records should be logically and consistently organized. The contents should be current, complete, meet documentation requirements and permit someone unfamiliar with the child to quickly acquire knowledge sufficient to provide service coordination or planning for the child or to review the records to assure compliance with contract, policy, standard or procedure. Service notes should provide a clear description of the circumstances being recorded. If person-to-person contacts are being documented, the content of the service note should clearly record the name of the contact person (including title, position or relationship to the child), the purpose of the contact, assessment of the situation, services provided, and goal or follow-up needed. Confidentiality of records should be observed according to DDSN policy.

Record Keeping

1. The primary case record will be kept in a secure location. Provider and DDSN confidentiality policies are to be followed, and must comply with HIPAA laws.

2. The primary case record must have an index that is followed and the contents in each section must be in chronological order. The record index must be readily available to persons reviewing the records. (See attachment 1 for sample record index)

3. The primary case record must contain:

    - A valid SCDDSN service agreement; if a DDSN service has been identified as a need;
    - SCDDSN eligibility documentation, once received;
    - BabyNet eligibility documentation, if applicable;
    - Service notes;
    - A current FSP, previous FSP;
    - MR/RD or HASCI waiver documentation if enrolled in waiver;
    - Current medical records
    - Current provider records (therapies);
    - Most recent psychological, if available;
    - Birth records, if needed;
    - Current IEP, if applicable;
    - Correspondence and any other documentation intended to support Medicaid reimbursement for early intervention;
    - Legal records determining a change in legal guardianship or documenting a legal name change, if applicable;
    - Other documents which from time to time may be deemed essential by DDSN or the state Medicaid agency;

- Family training summary sheets;
- Genetics Release Form; and,
- Current (within1 year) age appropriate assessment, unless the child is enrolled in public school and has a current IEP addressing their educational needs.

4. Contents purged from primary case record must also be maintained according to the record index, in chronological order, and in close proximity to the primary case record. The primary case record must note that there is a file containing purged contents. If the child is enrolled in any waiver, all MR/RD Waiver documents must remain in the working file at all times.

5. Closed case records must be retained for a period of no less than six (6) years after the end of the annual contract period. If any litigation, claims, or other actions involving the records are initiated prior to the expiration of the six (6) year period, the records must be retained until completion of the actions and resolution of all issues which arise from it or until the end of the required period, whichever is later.

6. If a provider discovers that they have "lost" a consumer's case record this MUST be reported to the Office of Children's Services immediately. Private providers should also notify the agency that holds their sub-contract.

Record Transfer:

Once it is determined that a case needs to be transferred to another county or provider the following steps must be taken:

1. Offer the family a choice of provider and have the family sign the Acknowledgment of SC/EI Provider Choice form;
2. Contact the provider of parental choice to inform them of the transfer;
3. Copy and mail the original file within two working days;
4. You must reconcile the waiver budget if applicable;
5. You must update the CDSS with the new contact information if it is available;
6. The receiving provider must contact the sending provider to inform them of the receipt of file.
7. Transfer the child to the new provider in CDSS once receipt of file is confirmed;

If a child is transferring from the Early Intervention Program to Service Coordination, prior to transfer, the EI must be discharge the child from Family Training in the Services Menu (SVMEN) within STS.

Documentation in Service Notes

1. Service notes must document all service coordination and/or family training activity on behalf of the child. It is particularly important that notes address health, safety and legal issues when applicable or family/legal guardian concerns and expressions of choice when they occur. Multiple actions which support the same function (intake, needs assessment, planning, FSP implementation, etc.) may be incorporated into a single service note provided those actions occurred at or about the same time;

2. All service notes must be typed or handwritten in black or dark blue ink. Photocopies of service notes may be placed in the primary case record, temporarily, if the originals have been forwarded to DDSN and if the photocopies are legible. Photocopies of service notes documenting concurrent activity on behalf of two or more children is not acceptable. Service notes must be individualized to the specific child represented by the primary case record;

3. All service notes must be placed in the file within seven calendar days from the date the service was rendered;

4. All service notes must be legible and kept in chronological order;

5. All entries must be dated and legibly signed with the Early Interventionist's name or initials and professional title. A signature/initial sheet including all current Early Interventionists and supervisors must be maintained in the Early Intervention office;

6. Late entries (entries to provide additional documentation to supplement entries previously written) may be necessary at times to handle omissions in the documentation. Late entries should be rarely used, and then only used to correct a genuine error of omission or to add new information that was not discovered until a later date. Whenever late entries are made, providers shall adhere to the following guidelines: Identify the new entry as a "late entry", enter the current date and time, identify or refer to the date and incident for which the late entry is written, validate the source of additional information as much as possible, document all information as soon as possible;

7. Each Early Intervention office must maintain a list of any abbreviations or symbols used in the records. This list must be clear as to the meaning of each abbreviation or symbol. Only abbreviations and symbols on this approved list may be used;

8. Persons referenced in service notes or any supporting correspondence must be identified by relationship to the child either once on each page or on a separate list located in each record;

9. When errors are made in service notes:

    - Clearly draw one line through the error, write the word "ERROR", enter the correct information, and add the Early Interventionist's signature or initials and date. If additional explanation is appropriate, this may be included.
    - The information contained in the error must remain legible.
    - No correction fluid or erasable ink may be used.

10. When a review reveals that a service note was not signed when written, the note must be signed immediately and that signature given the current date. A current service note must be written to explain the difference between the signature date and the date the note was actually written. If the activity described in the unsigned note had previously been reported on the SPL, this is not considered a reporting error that must be corrected;

11. There must be a service note documenting an activity for each service reported;

12. The content of the service note will contain sufficient detail to clearly communicate the purpose of the note and to document reportable activity if such is the case. All service notes do not have to document a reportable activity;

13. Written correspondence, pertinent oral communications, completed reports and completion/updates to the FSP must be documented in service notes to include identification in the record of any referenced documents; and

14. Service notes must document activities relevant to the needs of the child and family. (See attachment 2 for a sample service note form)

Note: If an Early Interventionist is serving multiple children in one family, they must document each child's services separately to include; summary of visit sheet and service notes.

Record Index

Each agency has a different method of organizing information. The following information can be used as a template.

Section 1: File Index
Consent to release and obtain information
Consent for evaluation and assessment
Service Agreement
BabyTrac
CDSS
Review of record log
Once the case is closed place the Closure form on top of this section

Section 2: IFSP/FSP

Eligibility Certification Letter

Section 3: Service Notes

Section 4: Summary of visits/data sheets (For FT providers)
IEP

Section5: Medical/Therapy information
Psychological Evaluations

Section 6: This section must be tabbed for each of the following:

- BabyNet Intake Information.
- Written Prior Notice/Meeting Notification.
- BabyNet Payment Authorizations / BabyNet Insurance Payment Authorization.
- Correspondence (Letters, referrals, Transition referral form etc…)
- Request for information.
- If pursuing eligibility for DDSN services place information here (CIS, Eligibility cover letter).
- MR/RD Waiver information, if applicable.

Service Notes

Child's Name:_____

Date	Activity SC/FT	Time Hr/min	Description of activity

Procedural Bulletin # 13
Attachment # 2